LONG-TERM CARE HOSPITALS PAYMENT SYSTEM

*payment***basics**

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Patients with clinically complex problems, such as multiple acute or chronic conditions, may need hospital care for relatively extended periods of time. Some are admitted to long-term care hospitals (LTCHs), which must have an average Medicare length of stay greater than 25 days. Payments to LTCHs were about $4.6 billion in 2005; Medicare beneficiaries accounted for about 70 percent of these hospitals' revenues. In 2004, 109,000 Medicare beneficiaries had 122,000 discharges from LTCHs, and 357 facilities were Medicare certified. LTCHs are not distributed evenly through the nation.

Beneficiaries transferred to an LTCH from an acute care hospital pay no additional deductible. However, beneficiaries admitted from the community are responsible for a deductible—$952 in 2006—as the first admission during a spell of illness, and for a copayment—$238 per day—for the 61st through 90th days. Beneficiaries treated in LTCHs use their hospital days, thus are covered for 90 days of hospital care per illness, with a 60-day lifetime reserve.[1]

Beginning in October 2002, LTCHs are paid predetermined per-discharge rates based primarily on the patient's diagnosis and market area wages.[2] Before then, LTCHs were paid for furnishing care to Medicare beneficiaries on the basis of their average costs per discharge, as long as they did not exceed the facility-specific limit that was adjusted annually.

Under the PPS, discharges are assigned to case-mix groups containing patients with similar clinical problems that are expected to require similar amounts of resources. Each case-mix group has a national relative weight reflecting the expected costliness of treatment for a patient in that category compared with that for the average LTCH patient.

Defining the long-term care hospital products Medicare buys

Under the prospective payment system (PPS) for care in LTCHs, Medicare sets payment rates for more than 500 types of case-mix groups called the long-term care diagnosis related groups (LTC–DRGs). These are the same groups of patients used for the acute care hospital PPS, although they have different relative weights. Patients are assigned to these treatment categories based on the discharge diagnosis, including the principal diagnosis, up to eight secondary diagnoses, up to six procedures performed, age, sex, and discharge status of the patient. LTCHs may receive partial payments for patients who do not receive a full course of treatment.

Setting the payment rates

The PPS payment rates cover all operating and capital costs that LTCHs would be expected to incur in furnishing covered services. The initial payment level (base rate) for a typical discharge is $38,086 for the 2007 rate year (July 2006 through June 2007).

The base rate is adjusted to account for differences in market area wages (Figure 1). The wage index adjustment is being phased in over five years. The labor-related portion of the base payment amount—76 percent—is multiplied by a version of the hospital wage index and the result is added to the nonlabor portion.[3] For LTCHs in Alaska and Hawaii, the nonlabor portion is adjusted by a cost of living adjustment (COLA) and added to the labor-related portion.[4] The adjusted rate for each market is multiplied by the relative weights for all LTC–DRGs to create local PPS payment rates.

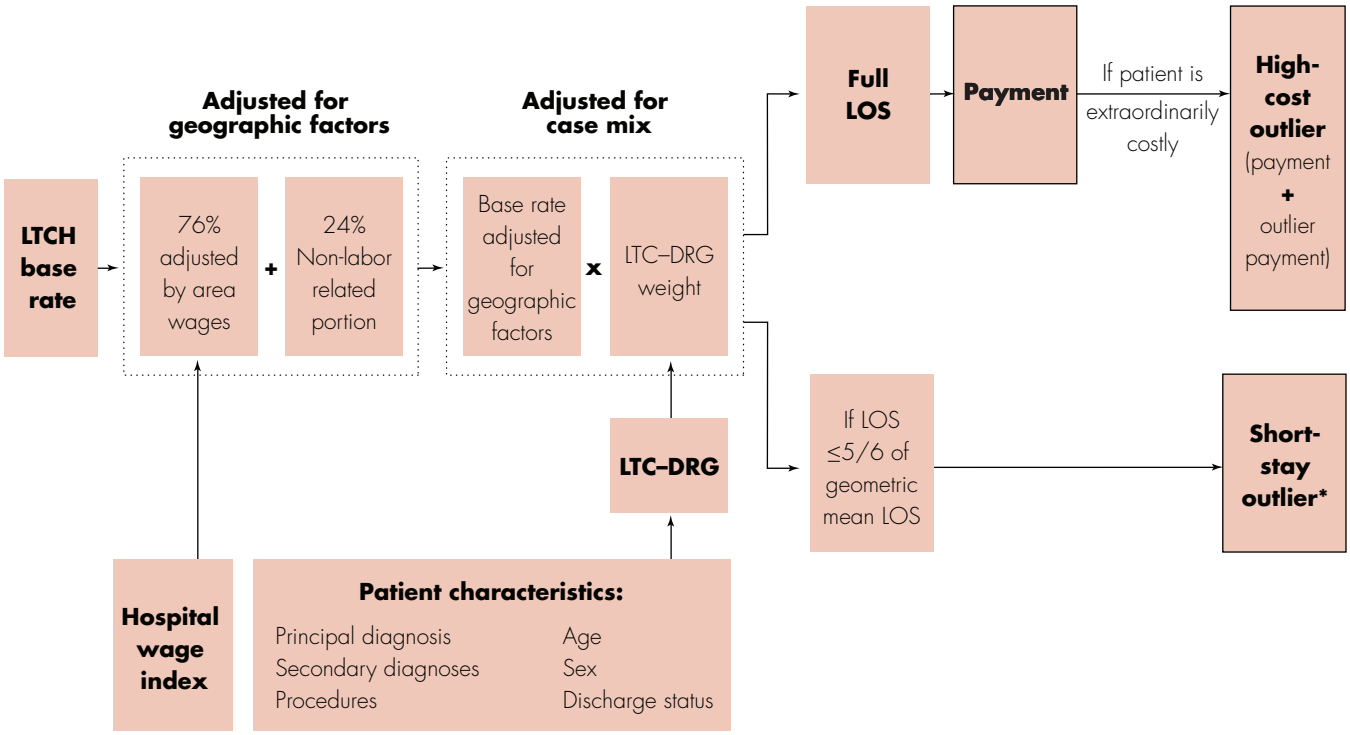
Relative weights for the LTC–DRGs differ from the acute care hospital diagnosis related group (DRG) weights. Medicare

This document does not reflect proposed legislation or regulatory actions.

MEDPAC

601 New Jersey Ave., NW
Suite 9000
Washington, DC 20001
ph: 202-220-3700
fax: 202-220-3759
www.medpac.gov

Figure 1 Long-term care hospital prospective payment system



Note: LTCH (long-term care hospital), LTC–DRG (long-term care diagnosis related group), LOS (length of stay).
* LTCHs are paid for short-stay outliers the least of: 100 percent of the cost of the case, 120 percent of the LTC–DRG specific per diem amount multiplied by the length of stay for that case, the full LTC–DRG payment, or a blend of the inpatient prospective payment system amount for the DRG and the 120 percent per diem payment amount.

assigns a weight to each LTC–DRG reflecting the average relative costliness of cases in the group compared with that for the average LTCH case. LTC–DRGs with less than 25 cases are grouped into 5 categories based on their average charges; relative weights for these 5 case-mix groups are determined based on the average charges for the LTC–DRGs in each of these groups.

LTCHs are paid adjusted PPS rates for patients who have short stays. Short-stay outliers (SSOs) are cases with a length of stay up to and including five-sixths of the geometric average length of stay for the LTC–DRG. For SSOs, LTCHs are paid the least of:

- 100 percent of the cost of the case,
- 120 percent of the LTC–DRG specific per diem amount multiplied by the length of stay for that case,
- the full LTC–DRG payment, or
- an amount that is a blend of the inpatient PPS amount for the DRG and the 120 percent of the LTCH per diem payment amount. As the length of stay for the SSO increases, the portion of payment attributable to the LTCH per diem increases.

LTCHs are paid outlier payments for patients who are extraordinarily costly. High-cost outlier cases are identified by comparing their costs to a threshold that is the DRG payment for the case plus a fixed loss amount. In 2007 the threshold is the LTC–DRG payment plus $14,887—the national fixed loss amount—adjusted to reflect the input price levels in the local market. Medicare pays 80 percent of the LTCHs' costs above their fixed loss thresholds. High-cost outlier payments are funded by reducing the base payment amount by 8 percent.

LTCHs receive one payment for "interrupted stay" patients. An interrupted stay is when a LTCH patient is discharged to an inpatient acute care hospital, an inpatient rehabilitation facility (IRF), or a skilled nursing facility (SNF) then stays for a specified period, then goes back to the same LTCH. The specified period of time is 9 days for an acute care hospital, 27 days for an IRF, and 45 days for a SNF. Any LTCH discharge readmitted within three days is also considered an interrupted stay.

Finally, Medicare has established two 5-percent thresholds to discourage transfers between LTCHs and co-located providers. (These 5-percent thresholds are independent of the 25 percent rule discussed below and the interrupted stay policy.) Medicare's concern about such transfers is that they may occur as a result of financial instead of clinical considerations. Each year, Medicare pays the LTCH for each discharge until 5 percent of all discharges are made up of transfers from the LTCH to the co-located acute care hospital and back. After the 5-percent threshold is met, though, these cases are paid as one LTCH admission rather than two. A separate 5-percent threshold applies to cases transferred to co-located SNFs, IRFs, and psychiatric facilities.

The 25 percent rule for hospitals within hospitals

CMS established a new policy—so-called 25 percent rule—to deter unbundling in the inpatient PPS. LTCH "hospitals within hospitals" (HWHs) should not function as units of host hospitals and decisions about admission, treatment, and discharge patterns should be made for clinical rather than financial reasons. The new 25 percent rule affects HWHs (and satellites treated the same as HWHs) and limits the proportion of patients who can be admitted from a HWH's host hospital during a cost reporting period. The policy will phase in over three years. HWHs will be paid LTCH PPS rates for patients admitted from the host acute care hospital when those patients are within the HWH threshold that year or are transferred to the LTCH after being high-cost outliers in the acute care hospital. After the threshold is reached, the LTCH is paid the lesser of the LTCH PPS rate or the acute hospital PPS rate. The threshold is:

- 75 percent for fiscal year 2006,
- 50 percent for fiscal year 2007, and
- 25 percent for fiscal year 2008.

There are some exceptions to the 25 percent rule. For rural HWHs, the applicable percentage is 50 percent. Urban single HWHs or those located in metropolitan statistical areas (MSAs) with dominant hospitals—those with one-fourth or more of acute care cases for the MSA—also have a threshold of 50 percent of cases.

Annual update and policy changes

On May 12, 2006, CMS published a final rule to update PPS rates for long-term care hospitals for the rate year beginning July 1, 2006 and ending June 30, 2007. The rule:

- Updates LTCH payment rates by zero percent, keeping the base rate $38,086 for 2006 and 2007.
- Increases the outlier threshold from $10,501 for 2006 to $14,887 for 2007.
- Changes the SSO policy as described earlier. ■

1 Beneficiaries are liable for a higher copayment for each lifetime reserve day—$476 per day in 2006.

2 LTCHs began receiving payments under the new PPS at the beginning of their 2003 cost reporting periods. During a five-year transition period, they are paid a blend of the PPS rate and their updated facility-specific rate. For example, in the first year of PPS, payments were made up of 20 percent PPS rates and 80 percent facility-specific rates; in the second year, payments were made up of 40 percent PPS rates and 60 percent facility-specific rates. LTCHs also could choose to be paid at 100 percent of the PPS rate; CMS estimates that more than 90 percent of LTCHs have chosen this option.

3 The wage index used to adjust LTCH payments is calculated from wage data reported by acute care hospitals without the effects of geographic reclassification.

4 The COLA is intended to reflect the higher costs of supplies and other nonlabor resources in Alaska and Hawaii. It increases the nonlabor portion of the payment by as much as 25 percent.